SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

LETTER OF NOTIFICATION – DENIAL/WITHDRAWAL
Medically Indigent Assistance Program

Date: _____

SECTION I

To:

From:

RE: _____
(Applicant's Name)

_____
(Name of Hospital)

SECTION II

PLEASE READ THE STATEMENT MARKED WITH AN "X" FOR INFORMATION ABOUT YOUR APPLICATION FOR ASSISTANCE THROUGH THE MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP).

☐ Your application for assistance through the MIAP for the period of hospitalization beginning _____ has been denied because

☐ At your request, your application for assistance through MIAP has been withdrawn.

Questions about this notice should be directed to:

_____ _____
(Name/Title) (Signature)

Telephone Number _____

Reconsideration

If you do not agree with the action taken on your application, you may request a reconsideration through your county government. This request must be made in writing within thirty (30) days of the date of this letter and must be directed to:

_____ at _____
(Name) (Address)
Telephone Number _____

Fair Hearing

I understand that if I believe an error has been made by the MIAP county designee in processing my MIAP Application, I may request a reconsideration. This request must be made in writing, within 30 days from the date of the decision notice, to the person designated by the county's chief administrative officer to make reconsideration decisions. I understand that if I believe an error has been made in the reconsideration decision, I have the right to appeal this decision at a hearing with SCDHHS, the agency that administers Medicaid in South Carolina. I may represent myself at the hearing, hire an attorney to help me or have someone speak on my behalf. I must submit a written request for a hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- Online at www.sc hhs.gov/appeals • Faxed to: 888-835-2086 • Emailed to: eligappeals@scdhhs.gov.
- Mailed to: SCDHHS – Central Mail, PO B x 100101, Columbia, SC 29202-3101, Attn:Eligibility Appeals

In the appeal request, I should specifically state which issue(s) I wish to appeal and attach a copy of the notification regarding the specific matter on appeal.

(For more information about the appeal process or what to include in your appeal request, go to www.scdhhs.gov/appeals, call 888-835-2039 or send an email to eligappeals@scdhhs.gov.)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။